

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Page 4

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
See Birth Cert. et  
CERTIFICATE OF DEATH

05723

1. PLACE OF DEATH a. COUNTY <b>FREDERICK MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>1dy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK Memorial</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Melinda</b> Middle <b>Anne</b> Last <b>Albert</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 May 60</b>
9. AGE (In years last birthday) <b>1</b>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>FRANCIS E. ALBERT</b>		14. MOTHER'S MAIDEN NAME <b>Felicia M. Riffle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hosp. Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 Atelectasis</b> DUE TO (b) <b>Immaturity</b> DUE TO (c) <b>Immaturity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1dy</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>29 May 1960</b> to <b>30 May 1960</b> , that (I) (we) last saw the deceased alive on <b>30 May 1960</b> , and that death occurred at <b>6:38</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>R.L. Guest</b>		22b. DATE SIGNED <b>30 May 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.L. Guest</b>		22d. ADDRESS <b>663rd St. Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-31-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 3 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

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MEDICAL CERTIFICATION

2

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10733

CERTIFICATE OF DEATH

10733



CERTIFICATE OF DEATH

Reg. Dist. No. 05724

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>BALL</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> , Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 17, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John L. Ball</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Cawood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-05-4464</b>	
17. INFORMANT <b>Mrs. Genevieve D. Ball- Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>5 Year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb.</b> , 19 <b>60</b> to <b>May 14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>May 9</b> , 19 <b>60</b> , and that death occurred at <b>8:00 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church Street</b> DATE SIGNED <b>5/16/60</b>			
ACTUAL SIGNATURE <b>Robert S. Turner, Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>Robert S. Turner, Jr., M.D.</b> <b>Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 17, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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5796

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				c. LENGTH OF STAY IN 1b <b>35</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>421 East Potomac Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Anna</b> First <b>Barbara</b> Middle <b>Barnett</b> Last				4. DATE OF DEATH <b>5</b> Month <b>3</b> Day <b>19</b> Year <b>60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-8-1879</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Mater</b>				14. MOTHER'S MAIDEN NAME <b>Anna?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. Laurence Nelson, Brunswick, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331x</b> IMMEDIATE CAUSE (a) <b>Central Nervous System</b> DUE TO <b>Suicide</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Suicide</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 7 mos.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1-18-1960</b> to <b>5-3-1960</b> that I last saw the deceased alive on <b>5-3-1960</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above. ADDRESS (Street, City or town, state) <b>Brunswick, Maryland</b> DATE SIGNED <b>5-5-60</b>							
ACTUAL SIGNATURE <b>C.E. Pruitt</b> M.D. <b>Brunswick, Maryland</b>							
PHYSICIAN'S NAME (Type) <b>C.E. Pruitt</b> <b>Brunswick, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-6-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters</b>		22d. LOCATION (City, town, or county) (State) <b>Harpers Ferry West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Felt</b> ADDRESS <b>Brunswick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

7506

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Name of physician

8. Name of registrar

9. Name of informant

10. Name of witness

11. Name of funeral home

12. Name of cemetery

13. Name of funeral home

14. Name of cemetery

15. Name of informant

16. Name of witness

17. Name of funeral home

18. Name of cemetery

19. Name of funeral home

20. Name of cemetery

21. Name of informant

22. Name of witness

23. Name of funeral home

24. Name of cemetery

25. Name of funeral home

26. Name of cemetery

27. Name of informant

28. Name of witness

29. Name of funeral home

30. Name of cemetery

31. Name of funeral home

32. Name of cemetery

33. Name of informant

34. Name of witness

35. Name of funeral home

36. Name of cemetery

37. Name of funeral home

38. Name of cemetery

39. Name of informant

40. Name of witness

41. Name of funeral home

42. Name of cemetery

43. Name of funeral home

44. Name of cemetery

45. Name of informant

46. Name of witness

47. Name of funeral home

48. Name of cemetery

49. Name of funeral home

50. Name of cemetery

51. Name of informant

52. Name of witness

53. Name of funeral home

54. Name of cemetery

55. Name of funeral home

56. Name of cemetery

57. Name of informant

58. Name of witness

59. Name of funeral home

60. Name of cemetery

61. Name of funeral home

62. Name of cemetery

63. Name of informant

64. Name of witness

65. Name of funeral home

66. Name of cemetery

67. Name of funeral home

68. Name of cemetery

69. Name of informant

70. Name of witness

71. Name of funeral home

72. Name of cemetery

73. Name of funeral home

74. Name of cemetery

75. Name of informant

76. Name of witness

77. Name of funeral home

78. Name of cemetery

79. Name of funeral home

80. Name of cemetery

81. Name of informant

82. Name of witness

83. Name of funeral home

84. Name of cemetery

85. Name of funeral home

86. Name of cemetery

87. Name of informant

88. Name of witness

89. Name of funeral home

90. Name of cemetery

91. Name of funeral home

92. Name of cemetery

93. Name of informant

94. Name of witness

95. Name of funeral home

96. Name of cemetery

97. Name of funeral home

98. Name of cemetery

99. Name of informant

100. Name of witness

101. Name of funeral home

102. Name of cemetery



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05726

Reg. Dist. No.

5755

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>15 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>840 North Market Street</b>		e. STREET ADDRESS <b>840 North Market Street</b>	
3. NAME OF DECEASED (Type or print) First <b>CLIFFORD</b> Middle <b>SAMUEL</b> Last <b>BIDDINGTON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 July 1874</b>
9. AGE (In years last birthday) yrs. <b>85</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Mt. Savage, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Biddington</b>		14. MOTHER'S MAIDEN NAME <b>Sarah (last name unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-1265</b>	
17. INFORMANT <b>Mrs. Ruth Eyler (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>591X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>prerenal azotemia</b> DUE TO <b>hypertension</b> (c) <b>heart</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1945</b> to <b>May 11, 1960</b> , that I last saw the deceased alive on <b>May 10, 1960</b> , and that death occurred at <b>5:45A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>228 N. Market St. Frederick, Maryland</b> DATE SIGNED <b>11 May 1960</b>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. <b>228 N. Market St. Frederick, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-13-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 13 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 65	
DATE OF DEATH 10-15-1955		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		OCCUPATION Retired	
DATE OF BIRTH 10-15-1890		PLACE OF BIRTH Maryland		CITY Baltimore	
FATHER'S NAME John Harris		MOTHER'S NAME Mary Harris		MARRIAGE DATE 1915	
EDUCATION High School		RELIGION Roman Catholic		MARITAL STATUS Married	
PREVIOUS ILLNESS Hypertension		TREATMENT Physician		HOSPITAL St. Joseph's	
DATE OF LAST ILLNESS 10-10-1955		DATE OF DEATH 10-15-1955		TIME OF DEATH 10:00 AM	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE		DATE		DATE	
PLACE		PLACE		PLACE	
CITY		CITY		CITY	
STATE		STATE		STATE	
ZIP CODE		ZIP CODE		ZIP CODE	
FEDERAL ID NUMBER		FEDERAL ID NUMBER		FEDERAL ID NUMBER	
MAYOR'S SIGNATURE		MAYOR'S SIGNATURE		MAYOR'S SIGNATURE	
DATE		DATE		DATE	
PLACE		PLACE		PLACE	
CITY		CITY		CITY	
STATE		STATE		STATE	
ZIP CODE		ZIP CODE		ZIP CODE	
FEDERAL ID NUMBER		FEDERAL ID NUMBER		FEDERAL ID NUMBER	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE OFFICIALS OF THE STATE DEPARTMENT OF HEALTH. IT IS NOT VALID IF SIGNED BY ANY OTHER OFFICIAL. IT IS NOT VALID IF SIGNED BY ANY OTHER OFFICIAL. IT IS NOT VALID IF SIGNED BY ANY OTHER OFFICIAL.



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05727

5797

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Emmitsburg,</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 29,</b>	
3. NAME OF DECEASED (Type or print) First <b>Mae</b> Middle <b>Alicene</b> Last <b>Campbell</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min. <b>80</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Emmitsburg, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James M. Kerrigan</b>		14. MOTHER'S MAIDEN NAME <b>Margaret D. Rosensteel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-32-0807</b>	
17. INFORMANT <b>Frances A. Blinson</b>		Address <b>Emmitsburg, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion -</b> <b>4201</b> DUE TO <b>arteriosclerotic cardiovascular disease - several years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension -</b> (c) <b>several years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 16, 1960</b> to <b>May 10, 1960</b> , that I last saw the deceased alive on <b>May 9, 1960</b> , and that death occurred at <b>2 M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>W R Cadle</b> M.D. <b>Emmitsburg, Maryland</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. W. R. Cadle</b>		Emmitsburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 13, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Catholic</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Frederick Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b>		ADDRESS <b>Emmitsburg, Md.</b>	
24a. REC'D BY REGISTRAR <b>C. E. Wilson</b>		24b. REGISTRAR'S SIGNATURE <b>C. E. Wilson</b>	

# CERTIFICATE OF DEATH

2737

MARYLAND STATE DEPARTMENT OF HEALTH-PART ONE IS

DECEASED'S NAME [Name]		SEX [Sex]		AGE [Age]		DATE OF BIRTH [Date]	
PLACE OF BIRTH [Place]		OCCUPATION [Occupation]		MARITAL STATUS [Status]		DATE OF DEATH [Date]	
CAUSE OF DEATH [Cause]		MANNER OF DEATH [Manner]		PLACE OF DEATH [Place]		TIME OF DEATH [Time]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF CORONER [Signature]	
SIGNATURE OF JUDGE [Signature]		SIGNATURE OF CLERK [Signature]		SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF DEPUTY REGISTRAR [Signature]	

NOT VALID

This certificate is valid only if it is filed in the office of the Registrar of the State Department of Health within the time specified in the law. It is not valid if it is filed in any other office.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05728

Reg. Dist. No.

5798

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.F.D.#3</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ford Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VIRGIE</b> Middle <b>ALICE</b> Last <b>CANNON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> , Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 21, 1890</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Wastler</b>		14. MOTHER'S MAIDEN NAME <b>Sarah A. Palmer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Mr. Lybert P. Cannon-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>  <b>420.1</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) _____  (c) _____</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b></p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 30, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 31 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Kraus</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH OFFICE

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Examination		Time of Examination		Place of Examination	
Witnesses		Physician		Nurse	
Funeral Home		Burial Place		Date of Burial	
Remarks		Remarks		Remarks	

MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND  
**5756** **CERTIFICATE OF DEATH** **05729**

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> <u>MAYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>5 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fredeniak Hospital</u>				e. STREET ADDRESS <u>208 Knox Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>X.</u> Last <u>COOK</u>				4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 6, 1886</u>	
9. AGE (In years, last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Hayman</u>				14. MOTHER'S MAIDEN NAME <u>Cindarella Pissel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>WA-242126</u>		17. INFORMANT <u>Mrs. Emma Buday, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>May 3, 1960</u> to <u>May 4, 1960</u> that (I) (we) last saw the deceased alive on <u>May 4, 1960</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. G. Pearce</u>				22b. DATE SIGNED <u>5/4/60</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>Frederick, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>May 7, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Burial Park</u>	
23d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



356

GENERAL OF DEATH

1055

Spice. 10/10/10

W. A. Brown  
May 10

✓  
Spice, 10/10  
May 10



5757

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>6 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1208 North Market Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>Kidd</b> Last <b>Derry</b>				4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1870</b>		9. AGE (In years last birthday) <b>90</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christopher Columbus Cecil</b>				14. MOTHER'S MAIDEN NAME <b>Mary Crawford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mrs. Edward R. Pearl 1208 N. Market Fred. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, sigmoid colon</b> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic C.V.D.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>2 years</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 10, 1959</b> , to <b>May 26, 1960</b> that I last saw the deceased alive on <b>May 25, 1960</b> , and that death occurred at <b>3 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. O. Thomas Jr.</b>		M.D. <b>Frederick, Md.</b>		ADDRESS (Street, city or town, state) <b>5/26/60</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas, Jr.</b>		M.D. <b>228 North Market St. Frederick, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey Jr.</b> ADDRESS <b>Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 31 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Mott</b>	

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BP

CERTIFICATE OF DEATH

1. Name of deceased	2. Sex	3. Age	4. Date of birth	5. Date of death	6. Place of death
7. Cause of death	8. Signature of physician	9. Signature of registrar	10. Signature of informant	11. Date of registration	12. Place of registration

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5758

CERTIFICATE OF DEATH

Items 8 & 9, Film G-263 5/31/60.eac.

05731

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>24 hrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont rural</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>	
3. NAME OF DECEASED (Type or print) First <b>Willis</b> Middle <b>Ray</b> Last <b>Devilbiss</b>		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1892 July 7, 1886</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Park Service</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Buchanan Devilbiss</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-18-0691</b>	
17. INFORMANT <b>Robert Devilbiss</b>		Address <b>Thurmont, Md. RD 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b> <b>3 yr +</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/11</b> <b>1960</b> , to <b>5/13</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>5/12</b> <b>1960</b> , and that death occurred at <b>3:30</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry V. Chase</b>		22b. DATE SIGNED <b>May 13, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>		22d. ADDRESS <b>4 E. Church St Frederick, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-16-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lewistown Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lewistown Fred. Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Bragan</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 16 '60</b>	
ADDRESS <b>Thurmont, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

100-1

UNITED STATES OF AMERICA

1957



Department of Health, Education and Welfare

Division of Health Care Services

Health Care Services Division

100-1

Health Care Services Division

Health Care Services Division

Health Care Services Division

Health Care Services Division

Health Care Services Division

Health Care Services Division

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5759

## CERTIFICATE OF DEATH

Reg. Dist. No.

05732

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Frederick</b></span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RFD # 1, Mt. Airy</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS 			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>NETTIE</b> Middle <b>IRENE</b> Last <b>DUVALL</b>				<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>12</b> , Year <b>1960</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 6, 1879</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>81</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Nursing</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Edward Houck</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Virginia Kemp</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>215-34-6681</b>		<b>17. INFORMANT</b> <b>Mr. Everest F. Duvall; RFD # 1, Mt. Airy</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolism</b> <b>433.1</b> DUE TO <b>Intracranial thrombus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiac vascular disease</b> DUE TO <b>Arteriosclerotic cardiac vascular disease</b> (c) <b>Arteriosclerotic cardiac vascular disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2-3 hours</b> <b>many years</b> <b>many years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiac vascular disease</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <b>July</b> , 19 <b>57</b> , to <b>May 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>May 11</b> , 19 <b>60</b> , and that death occurred at <b>8:35 A</b> M, from the causes and on the date stated above. <b>Ernest A. Dettbarn</b> M.D. ADDRESS (Street, city or town, state) DATE SIGNED <b>5/13/60</b>									
<b>ACTUAL SIGNATURE</b> <b>Ernest A. Dettbarn</b>				<b>PHYSICIAN'S NAME (Type)</b> <b>Dr. Ernest A. Dettbarn</b> <b>Walkersville, Maryland</b> <b>5/13/60</b>					
<b>22a. BURIAL, CREMATION, or other disposition</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>5/15/60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Glade Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Walkersville, Maryland</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M.R. Etchison &amp; Son; Frederick, Maryland</b>				<b>24a. REC'D BY REGISTRAR</b> <b>MAY 16 1960</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05733

5760

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>31 East Church Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Hammer Falk</b>		4. DATE OF DEATH <b>May 8, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 21, 1901</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Frederick County Treasurer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frederick, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. Falk</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth F. Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-10-2716</b>	
17. INFORMANT <b>Mrs. Harriet Shook Falk</b>		Address <b>308 Park Ave. Fred. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Coronary sclerosis</b> DUE TO (c) <b>3 weeks x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/21, 1959</b> , to <b>5/8, 1960</b> , that I last saw the deceased alive on <b>May 7, 1960</b> , and that death occurred at <b>1030</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick, Maryland</b> DATE SIGNED <b>5/9/60</b>			
ACTUAL SIGNATURE <b>S. R. Schoolman</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. L. R. Schoolman</b> <b>M.D. 228 N. Market St. Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 11, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey Jr.</b> ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 12 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: John T. Smith  
2. Sex: Male  
3. Age: 65  
4. Date of birth: Jan 15, 1900  
5. Place of birth: St. Louis, Mo.  
6. Usual residence: St. Louis, Mo.  
7. Cause of death: Heart disease  
8. Date of death: Jan 20, 1965  
9. Place of death: St. Louis, Mo.  
10. Signature of physician: Dr. J. H. Jones  
11. Signature of registrar: John T. Smith  
12. Signature of informant: John T. Smith

13. Name of informant: John T. Smith  
14. Address of informant: St. Louis, Mo.  
15. Signature of informant: John T. Smith  
16. Date of completion: Jan 20, 1965  
17. Registrar's signature: John T. Smith  
18. Registrar's name: John T. Smith  
19. Registrar's address: St. Louis, Mo.  
20. Registrar's phone: St. Louis, Mo.

CERTIFICATE OF DEATH

05734

Reg. Dist. No.

5761

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b> <b>06X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSP</b>				d. STREET ADDRESS <b>RURAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grace MAE Flickinger</b>				4. DATE OF DEATH Month Day Year <b>May 12 1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 16 - 1889</b>	
9. AGE (In years lost birthday) <b>70</b> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>CHARLES WAGNER</b>				14. MOTHER'S MAIDEN NAME <b>CAROLINE HORTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-30-1883</b>			
17. INFORMANT Address <b>LEE FLICKINGER UNION BRIDGE MD</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>Diabetes mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 9</b> , 19 <b>60</b> , to <b>May 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>May 12</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D.				ADDRESS (Street, city or town, state) <b>4 E. Church St</b> DATE SIGNED <b>5/13/60</b>			
PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>				<b>Frederick Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/15/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LUTHERAN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>UNIONTOWN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DD Hartley</b> ADDRESS <b>Union Bridge MD</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>	

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2381

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

05735  
Reg. Dist. No.

5799

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont-Rural-R.D.#1</b>		c. LENGTH OF STAY IN lb <b>3 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Lewistown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>HENRY</b> Last <b>FOGLE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> , Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1871</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>	IF UNDER 24 HRS. Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clay Shed</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Ephriam Fogle</b>	
14. MOTHER'S MAIDEN NAME <b>Harriett Albaugh</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mr. Raymond Fogle, Frederick, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 12, 1956</b> , to <b>May 26, 1960</b> , that I last saw the deceased alive on <b>May 17, 1960</b> , and that death occurred at <b>12 P</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Professional Building Frederick, Maryland</b> DATE SIGNED <b>5/27/60</b>	
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.		PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS <b>Frederick, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 31 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

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The undersigned, being a duly qualified and licensed physician, do hereby certify that the within and foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the State of Maryland, and that the same is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the State of Maryland.

(M)

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		35		JAN 15 1885		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Carpenter		High School		Married		Roman Catholic		White		White		Brown		Blue	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Heart Disease		Natural		3 Months		JAN 15 1920		BALTIMORE		MD		MD		USA	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF WITNESSES		DATE		SIGNATURE OF DECEASED		DATE		SIGNATURE OF DECEASED		DATE	
J. H. Harris		JAN 15 1920		J. H. Harris		JAN 15 1920		J. H. Harris		JAN 15 1920		J. H. Harris		JAN 15 1920	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05736

5800

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jail--West South St.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>-</b>	
3. NAME OF DECEASED (Type or print) <b>Garland Leomer Forrest</b>		4. DATE OF DEATH Month <b>5</b> Day <b>25</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Do not know</b>
9. AGE (in years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>George H. Forrest</b>		14. MOTHER'S MAIDEN NAME <b>Winona Gaier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Don't know</b>	
17. INFORMANT <b>Carroll H. Forrest, Brunswick, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute bronchial Pneumonia</b> <b>495X 43</b> DUE TO <b>Acute cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aortic Stenosis -</b> DUE TO <b>Sub-acute Bacterial Endocarditis</b> (c) <b>Chronic Alcoholism</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-27-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Galt</b>		24a. REC'D BY REGISTRAR <b>JUN 1 '60</b>	
ADDRESS <b>Brunswick, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in agreement within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

NAME OF DECEASED: George J. Jones

AGE: 45 SEX: Male

DATE OF DEATH: July 15, 1945

PLACE OF DEATH: Home

CAUSE OF DEATH: Myocardial Infarction

IMMEDIATE CAUSE: Coronary Thrombosis

UNDERLYING CAUSE: Arteriosclerosis

DATE OF EXAMINATION: July 16, 1945

TIME OF EXAMINATION: 10:00 AM

PLACE OF EXAMINATION: Home

NAME OF EXAMINER: Dr. J. H. Smith

ADDRESS OF EXAMINER: 123 Main St., Baltimore, Md.

SIGNATURE OF EXAMINER: [Signature]

DATE OF SIGNATURE: July 16, 1945

1

1 *4*  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5762 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <del>Pa.</del> b. COUNTY <b>Fulton</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burnt Cabins</b> <i>75x-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. STREET ADDRESS <b>Dublin Twnshp</b>	
3. NAME OF DECEASED (Type or print) <b>Roy</b>		4. DATE OF DEATH <b>May 22</b> 19 <b>60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1897</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Constructor worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plasterer</b>	
11. BIRTHPLACE (State or territory) <b>Fulton Co Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William W.B. Fraker</b>		14. MOTHER'S MAIDEN NAME <b>Lilly May Comerer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1 W.W. 193-05-0302</b>	
17. INFORMANT <b>Dr. Frank Demogno and Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>Mr Robert House McConnelsburg</b>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound fracture of skull with torn brain tissue</b> DUE TO (b) <b>Crushed shest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
36 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto he was driving turned in front of trailer tract</b>	
20c. TIME OF INJURY Month, Day, Year <b>5-10-60 5/20 1960</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40</b>		20f. (City or town) (County) <b>Frederick Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas</i>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B.O. Thomas, MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 22, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/25/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Burnt Cabins Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Burnt Cabins Fulton Co Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Charles L. Thomas</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR THE  
MEDICAL  
EXAMINER  
OF THE  
STATE OF  
NEW YORK  
IN THE  
MATTER OF  
THE  
Estate of  
JAMES  
J. HOGAN  
DECEASED

WESTBURY STATE DEPARTMENT OF HEALTH - BATHING 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: JAMES J. HOGAN  
2. Date of death: MAY 22, 1932  
3. Place of death: 123-08-0200  
4. Age: 65 years  
5. Sex: Male  
6. Race: White  
7. Occupation: Farmer  
8. Cause of death: Coronary thrombosis  
9. Manner of death: Natural  
10. Signature of Medical Examiner: [Signature]  
11. Date of certification: MAY 23, 1932  
12. Office of Medical Examiner: [Signature]  
13. County: [Signature]  
14. State: New York

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5801

## CERTIFICATE OF DEATH

05738  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b>		c. LENGTH OF STAY IN 1b <b>Since 2-60</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vindobona Convalescent &amp; Rest Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson</b>	
d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>FRANK</b> Last <b>FRY</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 May 1878</b>
9. AGE (In years by birthday) yrs. <b>82</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Springfield, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David C. Fry</b>		14. MOTHER'S MAIDEN NAME <b>Emma R. Feaster</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William E. Fry</b> (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Smile &amp; Lamentation</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Generalized Arteriosclerosis 2 yrs</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 1959</b> to <b>5/31, 1960</b> , that I last saw the deceased alive on <b>5/26, 1960</b> and that death occurred at <b>3:25 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Jefferson, Md.</b> DATE SIGNED <b>31 May 1960</b>			
ACTUAL SIGNATURE <b>A. T. Brice</b>		M.D. <b>Jefferson, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. T. Brice, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-2-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Jefferson, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 3 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



WYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
5802  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05739

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burkittsville</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burkittsville</u> X d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Arthur</u> Last <u>Guyton</u>		4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/1932</u>
9. AGE (In years lost birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min. <u>27</u>	11. IF UNDER 24 HRS. Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min. <u>27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Arthur Guyton</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Zecher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Arthur Guyton, Burkittsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>353.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant &amp; Pressure ulcers</u> DUE TO (c) <u>Severe Epilepsy Post Encephalitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 yr</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 27 1960</u> to <u>May 1 1960</u> , that (I) (we) last saw the deceased alive on <u>April 27 1960</u> and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A. T. BRIEF</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A T BRIEF</u>		22d. ADDRESS <u>Bederson Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>5/3/1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company,</u>		25a. REC'D BY REGISTRAR <u>MAY 4 60</u>	
ADDRESS <u>Middletown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1902

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05740

5803

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Mt. Airy</b>				c. LENGTH OF STAY IN 1b <b>years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD # 3</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Katie</b> Middle <b>--</b> Last <b>Hagan</b>				4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1873</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jeremiah McCarthy</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ellen McCarthy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>		INFORMANT Address <b>Mrs Marie Mertz, 37 E. Osten, Balti. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive + Arteriosclerotic Heart Disease</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>over 10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>60</b> , to <b>May</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>May 10</b> , 19 <b>60</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>W.B. Culwell</b> M.D. <b>Arthur S. Hume</b> <b>5/12/60</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>W.B. Culwell</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 14, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels</b>		22d. LOCATION (City, town, or county) (State) <b>Poplar Springs, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Mohrman</b>		ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont RURAL</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ow Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MORRIS</b> First <b>HOWARD</b> Middle <b>HAHN</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1902</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Odd Jobs</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard H. Hahn</b>		14. MOTHER'S MAIDEN NAME <b>Sarah A. Sweeney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-3979</b>	
17. INFORMANT <b>Margaret C. Hahn</b>		Address <b>Thurmont, Md. RD 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1 -</b> , 19 <b>60</b> , to <b>May 29</b> , 19 <b>60</b> that I last saw the deceased alive on <b>May 29</b> , 19 <b>60</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont - Md.</b> DATE SIGNED <b>May 30 - 60</b>			
ACTUAL SIGNATURE <b>James K. Gray</b>		M.D. <b>Thurmont - Md.</b>	
PHYSICIAN'S NAME (Type) <b>James K. Gray</b>		<b>Thurmont, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-31-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1971

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
James E. Jones		Male		50 yrs.		Sept. 12, 1921		New York, N.Y.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Retired		High School		Catholic	
Physician's Signature		Physician's Name		Physician's Address		Physician's Phone		Physician's License No.	
[Signature]		Dr. J. A. Brown		123 Main St., New York, N.Y.		(212) 555-1234		12345	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Place	
St. John's Church		Sept. 15, 1971		10:00 AM		St. John's Church		St. John's Church	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Place	
St. John's Church		Sept. 15, 1971		10:00 AM		St. John's Church		St. John's Church	



## CERTIFICATE OF DEATH

05742

Reg. Dist. No.

5763

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b Days <b>X</b> <b>Dickerson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>Rock Hall Manor</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>GORDON</b> Last <b>HARRIS</b>				4. DATE OF DEATH Month <b>May</b> Day <b>13</b> , Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 25, 1884</b>		9. AGE (In years lost birthday) yrs. <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Gordon</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Cruzen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Mrs. Robert D. Harris - Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accidents, multiple</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Laennec's Cirrhosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Laennec's Cirrhosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 1959</b> , to <b>May 1960</b> , that I last saw the deceased alive on <b>May 13, 1960</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9 E. Church St., Frederick, Maryland</b> DATE SIGNED <b>5/14/60</b>							
ACTUAL SIGNATURE <b>Richard C. Reynolds</b> PHYSICIAN'S NAME (Type) <b>RICHARD C. REYNOLDS, M.D.</b> <b>Frank Damazo, Jr., M.D.</b>				M.D. <b>Walter H. Smith</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 16, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAY 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5764

## CERTIFICATE OF DEATH

05743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville</u> 15X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Reeder</u> Last <u>HEWITT</u>		4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1-1924</u> 35 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Caudell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Branson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Estel Hewitt, Barnesville Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia (Right lower lobe)</u> DUE TO <u>002X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lt. Thoracoplasty in 1947 (Pulmonary TB)</u> DUE TO (c) <u>Malnutrition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>13 yrs</u> <u>Lifetime?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 22, 1960</u> , to <u>May 23, 1960</u> , that I last saw the deceased alive on <u>May 22, 1960</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Ralph L. Michels</u> M.D.		<u>Shopping Center</u>	
PHYSICIAN'S NAME (Type) <u>Ralph L. Michels</u>		<u>Frederick, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/25/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u>		ADDRESS <u>Barnesville, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

CERTIFICATE OF DEATH

X

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15, 1945</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. DATE OF BIRTH <i>Jan 1, 1900</i>		11. TIME OF BIRTH <i>10:30 AM</i>		12. PLACE OF BIRTH <i>Baltimore, Md.</i>	
13. NAME OF FATHER <i>John Doe</i>		14. NAME OF MOTHER <i>John Doe</i>		15. NAME OF SPOUSE <i>John Doe</i>	
16. NAME OF CHILD <i>John Doe</i>		17. NAME OF CHILD <i>John Doe</i>		18. NAME OF CHILD <i>John Doe</i>	
19. NAME OF CHILD <i>John Doe</i>		20. NAME OF CHILD <i>John Doe</i>		21. NAME OF CHILD <i>John Doe</i>	
22. NAME OF CHILD <i>John Doe</i>		23. NAME OF CHILD <i>John Doe</i>		24. NAME OF CHILD <i>John Doe</i>	
25. NAME OF CHILD <i>John Doe</i>		26. NAME OF CHILD <i>John Doe</i>		27. NAME OF CHILD <i>John Doe</i>	
28. NAME OF CHILD <i>John Doe</i>		29. NAME OF CHILD <i>John Doe</i>		30. NAME OF CHILD <i>John Doe</i>	
31. NAME OF CHILD <i>John Doe</i>		32. NAME OF CHILD <i>John Doe</i>		33. NAME OF CHILD <i>John Doe</i>	
34. NAME OF CHILD <i>John Doe</i>		35. NAME OF CHILD <i>John Doe</i>		36. NAME OF CHILD <i>John Doe</i>	
37. NAME OF CHILD <i>John Doe</i>		38. NAME OF CHILD <i>John Doe</i>		39. NAME OF CHILD <i>John Doe</i>	
40. NAME OF CHILD <i>John Doe</i>		41. NAME OF CHILD <i>John Doe</i>		42. NAME OF CHILD <i>John Doe</i>	
43. NAME OF CHILD <i>John Doe</i>		44. NAME OF CHILD <i>John Doe</i>		45. NAME OF CHILD <i>John Doe</i>	
46. NAME OF CHILD <i>John Doe</i>		47. NAME OF CHILD <i>John Doe</i>		48. NAME OF CHILD <i>John Doe</i>	
49. NAME OF CHILD <i>John Doe</i>		50. NAME OF CHILD <i>John Doe</i>		51. NAME OF CHILD <i>John Doe</i>	
52. NAME OF CHILD <i>John Doe</i>		53. NAME OF CHILD <i>John Doe</i>		54. NAME OF CHILD <i>John Doe</i>	
55. NAME OF CHILD <i>John Doe</i>		56. NAME OF CHILD <i>John Doe</i>		57. NAME OF CHILD <i>John Doe</i>	
58. NAME OF CHILD <i>John Doe</i>		59. NAME OF CHILD <i>John Doe</i>		60. NAME OF CHILD <i>John Doe</i>	
61. NAME OF CHILD <i>John Doe</i>		62. NAME OF CHILD <i>John Doe</i>		63. NAME OF CHILD <i>John Doe</i>	
64. NAME OF CHILD <i>John Doe</i>		65. NAME OF CHILD <i>John Doe</i>		66. NAME OF CHILD <i>John Doe</i>	
67. NAME OF CHILD <i>John Doe</i>		68. NAME OF CHILD <i>John Doe</i>		69. NAME OF CHILD <i>John Doe</i>	
70. NAME OF CHILD <i>John Doe</i>		71. NAME OF CHILD <i>John Doe</i>		72. NAME OF CHILD <i>John Doe</i>	
73. NAME OF CHILD <i>John Doe</i>		74. NAME OF CHILD <i>John Doe</i>		75. NAME OF CHILD <i>John Doe</i>	
76. NAME OF CHILD <i>John Doe</i>		77. NAME OF CHILD <i>John Doe</i>		78. NAME OF CHILD <i>John Doe</i>	
79. NAME OF CHILD <i>John Doe</i>		80. NAME OF CHILD <i>John Doe</i>		81. NAME OF CHILD <i>John Doe</i>	
82. NAME OF CHILD <i>John Doe</i>		83. NAME OF CHILD <i>John Doe</i>		84. NAME OF CHILD <i>John Doe</i>	
85. NAME OF CHILD <i>John Doe</i>		86. NAME OF CHILD <i>John Doe</i>		87. NAME OF CHILD <i>John Doe</i>	
88. NAME OF CHILD <i>John Doe</i>		89. NAME OF CHILD <i>John Doe</i>		90. NAME OF CHILD <i>John Doe</i>	
91. NAME OF CHILD <i>John Doe</i>		92. NAME OF CHILD <i>John Doe</i>		93. NAME OF CHILD <i>John Doe</i>	
94. NAME OF CHILD <i>John Doe</i>		95. NAME OF CHILD <i>John Doe</i>		96. NAME OF CHILD <i>John Doe</i>	
97. NAME OF CHILD <i>John Doe</i>		98. NAME OF CHILD <i>John Doe</i>		99. NAME OF CHILD <i>John Doe</i>	
100. NAME OF CHILD <i>John Doe</i>		101. NAME OF CHILD <i>John Doe</i>		102. NAME OF CHILD <i>John Doe</i>	

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5765 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05744  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Work</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Everedy Company</b>		d. STREET ADDRESS <b>232 East Second Street</b>	
3. NAME OF DECEASED (Type or print) <b>LEONARD</b> <b>ELSWORTH</b> <b>HOSSLER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 1908</b>
9. AGE (In years (or birthday)) <b>51</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman <del>Company</del></b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jesse S. Hossler</b>		14. MOTHER'S MAIDEN NAME <b>Alice Waltz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-2164</b>	
17. INFORMANT <b>Mrs. Virginia Hossler-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO (b) <b>Arterio-Sclerotic Vascular Heart Disease</b> DUE TO (c) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1-Yr. Plus</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 5, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 6 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>G. L. S. H. H. H.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT

198

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		M		W		4-4-68	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP	
MEMPHIS		MEMPHIS		MEMPHIS		TN		38103	
OCCUPATION		CITY		COUNTY		STATE		ZIP	
ATTORNEY		MEMPHIS		MEMPHIS		TN		38103	
EDUCATION		CITY		COUNTY		STATE		ZIP	
HIGH SCHOOL		MEMPHIS		MEMPHIS		TN		38103	
UNIVERSITY		MEMPHIS		MEMPHIS		TN		38103	
MARRIED		CITY		COUNTY		STATE		ZIP	
SINGLE		MEMPHIS		MEMPHIS		TN		38103	
DIVORCED		CITY		COUNTY		STATE		ZIP	
WIDOWED		MEMPHIS		MEMPHIS		TN		38103	
MILITARY SERVICE		CITY		COUNTY		STATE		ZIP	
ARMY		MEMPHIS		MEMPHIS		TN		38103	
NAVY		CITY		COUNTY		STATE		ZIP	
AIR FORCE		MEMPHIS		MEMPHIS		TN		38103	
MARINE CORPS		CITY		COUNTY		STATE		ZIP	
COAST GUARD		MEMPHIS		MEMPHIS		TN		38103	
OTHER		CITY		COUNTY		STATE		ZIP	
NONE		MEMPHIS		MEMPHIS		TN		38103	
REASON FOR DEATH		CITY		COUNTY		STATE		ZIP	
HEART DISEASE		MEMPHIS		MEMPHIS		TN		38103	
CANCER		CITY		COUNTY		STATE		ZIP	
STROKE		MEMPHIS		MEMPHIS		TN		38103	
PNEUMONIA		CITY		COUNTY		STATE		ZIP	
TUBERCULOSIS		MEMPHIS		MEMPHIS		TN		38103	
DIABETES		CITY		COUNTY		STATE		ZIP	
HYPERTENSION		MEMPHIS		MEMPHIS		TN		38103	
MISCELLANEOUS		CITY		COUNTY		STATE		ZIP	
NONE		MEMPHIS		MEMPHIS		TN		38103	
CAUSE OF DEATH		CITY		COUNTY		STATE		ZIP	
HEART DISEASE		MEMPHIS		MEMPHIS		TN		38103	
CANCER		CITY		COUNTY		STATE		ZIP	
STROKE		MEMPHIS		MEMPHIS		TN		38103	
PNEUMONIA		CITY		COUNTY		STATE		ZIP	
TUBERCULOSIS		MEMPHIS		MEMPHIS		TN		38103	
DIABETES		CITY		COUNTY		STATE		ZIP	
HYPERTENSION		MEMPHIS		MEMPHIS		TN		38103	
MISCELLANEOUS		CITY		COUNTY		STATE		ZIP	
NONE		MEMPHIS		MEMPHIS		TN		38103	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
TO CHIEF MEDICAL EXAMINER: This certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the Chief Medical Director, Page  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5765

05745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>7 hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		15X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Brouse Leo Honck</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 2, 1905</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rented Farms</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Honck</u>				14. MOTHER'S MARDEN NAME <u>Viola Frushour</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Card Lost</u>		17. INFORMANT <u>Mrs. Helen Honck, Poolersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>B. O. Thomas</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B. O. Thomas, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/22/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May. 26. 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lewistown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Lewistown Fredk. Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

Raymond E. Creager

X

5

[illegible]

523 522

may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
M  
5767  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
05746

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>1 hour</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Catherine R.</b> Middle <b>Kepler</b> Last <b>Kepler</b>				4. DATE OF DEATH Month <b>5</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/28/1886</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>19</b> Min.		11. IF UNDER 24 HRS. Months <b>5</b> Days <b>10</b> Hours <b>19</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Singleton E. Rensburg</b>				14. MOTHER'S MAIDEN NAME <b>Frances Shafer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>213-24-7844</b>		17. INFORMANT <b>Mrs. Hilda Korrell, Middletown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Acute Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <b>1954</b> to <b>5/10</b> 19 <b>60</b> that (2) (we) last saw the deceased alive on <b>5/10</b> 19 <b>60</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Kenneth C. Henson</b>				22b. PHYSICIAN'S NAME (Type) <b>Dr. Kenneth C. Henson</b>		22c. DATE SIGNED <b>5/10/60</b>	
22d. ADDRESS <b>Middletown, Md.</b>				22e. ADDRESS <b>Middletown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				23b. DATE THEREOF <b>5/13/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>				23e. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

069

1

OP

CERTIFICATE OF DEATH

2767

05340

Blank certificate form with faint horizontal lines and vertical columns for data entry.

5768

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (If deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARLTON T. KING</b>		4. DATE OF DEATH Month Day Year <b>May 6, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 20, 1902</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner &amp; Sec. Dairy.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy Business</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick County Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>J. Otis King</b>		14. MOTHER'S MAIDEN NAME <b>Nettie Yingling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-20-9127</b>	
17. INFORMANT <b>Miss. Catherine Thomas</b>		Address <b>302, College Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary acc. lusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 5/6, 1959</b> to <b>5/6, 1960</b> , that I last saw the deceased alive on <b>5/6, 1960</b> , and that death occurred at <b>10:55 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5/8/60</b>			
ACTUAL SIGNATURE <b>James B. Thomas</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>JAMES B. THOMAS</b>		Professional Bldg., 228, N. Market St.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>May 9, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey</b> ADDRESS <b>DALLEY'S FUNERAL HOME, FREDERICK, Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 12 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1934

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05748

5804

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adamstown-Rural RD#1</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adamstown-Rural RD#1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Near Buckeystown</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>ELIAS</b> Last <b>KRISE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 May 1890</b>
9. AGE (In years lost birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Greagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward L. Krise</b>		14. MOTHER'S MAIDEN NAME <b>America A. Hankey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-36-2694</b>	
17. INFORMANT <b>Mrs. Hazel E. Krise</b>		Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-4-</b> , <b>1955</b> , to <b>5-16-</b> , <b>1960</b> , that I last saw the deceased alive on <b>2-17-</b> , <b>1960</b> , and that death occurred at <b>3:45 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>220 N. Market St.</b> DATE SIGNED <b>18 May 1960</b>			
ACTUAL SIGNATURE <b>Rex R. Martin</b>		M.D. <b>Frederick, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-19-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>MAY 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5789

CERTIFICATE OF DEATH

05749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Brunswick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrott Nursing Home</b>				e. STREET ADDRESS <b>1 102 9th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>-</b> Last <b>LaPole</b>				4. DATE OF DEATH Month <b>5</b> Day <b>31</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-3-1888</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.	IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R. R. Co</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William LaPole</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Moore</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mr. Milliard E. LaPole, Baltimore, Md.</b>		INFORMANT Address <b>Mr. Milliard E. LaPole, Baltimore, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Seriously</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>11 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-23-1960</b> to <b>5-31-1960</b> , that I last saw the deceased alive on <b>5-31-1960</b> , and that death occurred at <b>C.A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C.E. Pruitt</b>		M.D. <b>Brunswick, Md</b>		ADDRESS (Street, city or town, state) <b>Brunswick, Maryland</b>		DATE SIGNED <b>6-3-60</b>	
PHYSICIAN'S NAME (Type) <b>C.E. Pruitt</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-3-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reformed</b>		22d. LOCATION (City, town, or county) (State) <b>Knoxville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Pruitt</b>				ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 7 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

2057

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5769

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R D 2 15X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hosp</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Earl</u> First <u>Lechlider</u> Middle <u>Lechlider</u> Last		4. DATE OF DEATH <u>May</u> Month <u>2</u> Day <u>1960</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/9/1898</u>
9. AGE (in years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Lechlider</u>		14. MOTHER'S MAIDEN NAME <u>Marion Baldwin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-32-5355</u>	
17. INFORMANT <u>Mrs Myrtle Lechlider</u> Address <u>Gaithersburg R D 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 2, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-5-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 9 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE STATE HEALTH DEPARTMENT, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT. IT IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT. IT IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED  
NAME  
AGE  
SEX  
RACE  
OCCUPATION  
RESIDENCE  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF EXAMINER  
DATE OF EXAMINATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SIGNATURE OF EXAMINER

DATE OF EXAMINATION

LOCAL HEALTH DEPARTMENT

STATE HEALTH DEPARTMENT

U.S. DEPARTMENT OF HEALTH

U.S. BUREAU OF VITAL STATISTICS

U.S. DEPARTMENT OF COMMERCE

U.S. BUREAU OF CENSUS

U.S. DEPARTMENT OF AGRICULTURE

U.S. BUREAU OF MINES

U.S. DEPARTMENT OF LABOR

U.S. BUREAU OF LABOR STATISTICS

U.S. DEPARTMENT OF JUSTICE

U.S. BUREAU OF PRISONS

U.S. DEPARTMENT OF WAR

U.S. BUREAU OF MILITARY MEDICINE

U.S. DEPARTMENT OF NAVY

U.S. BUREAU OF NAVAL MEDICINE



05751

5770

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#7</b>				c. LENGTH OF STAY IN 1b <b>13 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick County Chronic Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#3</b>			
f. STREET ADDRESS <b>Mountindale</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLAUDE OLIVER LENHART</b>				4. DATE OF DEATH Month Day Year <b>May 28, 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>29 Oct 1900</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Road Work - M. J. Grove Line Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clayton C. Lenhart</b>				14. MOTHER'S MAIDEN NAME <b>Effie E. White</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-8637</b>		17. INFORMANT <b>Miss Ruth I. Lenhart (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 16, 1960</b> , to <b>May 27, 1960</b> , that I last saw the deceased alive on <b>May 27, 1960</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7 N. Market St. Frederick, Md.</b> DATE SIGNED <b>31 May 1960</b>							
ACTUAL SIGNATURE <b>H. F. Kline</b>		M.D. <b>H. F. Kline, M. D.</b>		Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-1-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Date of Death [Illegible]	
Age of Deceased [Illegible]		Sex of Deceased [Illegible]	
Usual Residence [Illegible]		Place of Death [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]	
Physician's Signature [Illegible]		Registrar's Signature [Illegible]	
Date of Certificate [Illegible]		Office of Registrar [Illegible]	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05752

5771

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. LENGTH OF STAY IN 1b <b>Years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Frederick-Rural- R.F.D.#3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>Yellow Springs</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Elise</b> Last <b>Linton</b>				4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 15, 1882</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Linton</b>				14. MOTHER'S MAIDEN NAME <b>Clara Nusz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-9301</b>		17. INFORMANT Address <b>Mrs. Pearl E. Linton-Same as Item #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute Bronchitis &amp; Pneumonia</b> DUE TO (b) <b>chronic Bronchitis &amp; Pneumonia</b> DUE TO (c) <b>B. Histoplasmosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>April 12, 1960</b> to <b>May 1, 1960</b> that (I) (we) last saw the deceased alive on <b>May 1, 1960</b> , and that death occurred at <b>7 P.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Jesse S. Fifer</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>MAY 2, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Jesse S Fifer</b>		22d. ADDRESS <b>801 Tall House AVE Frederick Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 5, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 6 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05753

5772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	c. LENGTH OF STAY IN lb <u>3 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Monrovia RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Franklin Linwood Lucas</u>		4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1941</u>
9. AGE (in years, last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post. Brn. Major</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick Co</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
13. FATHER'S NAME <u>Wernie Leo Lucas</u>		14. MOTHER'S MAIDEN NAME <u>Blanche D. Printz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-42-1819</u>	
17. INFORMANT <u>Wernie L. Lucas</u>		Address <u>Monrovia RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Base of Skull</u> 823X DUE TO <u>Fracture left right side ribs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Fractured Sternum</u> (b) <u>Fractured pelvis</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto skidded over embankment &amp; struck a tree</u>	
20c. TIME OF INJURY Month, Day, Year <u>5/12/60</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Engelwood Rd in New Market Frederick Md</u>	20f. (City or town) (County) (State) <u>Frederick Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. O. Thomas</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. Thomas, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 12-1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 15, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm L. Moleworth</u>		24. REC'D BY REGISTRAR DATE <u>MAY 17 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Reed</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

ROOM 10

1. Name of Deceased: \_\_\_\_\_

2. Sex: ☐ Male ☐ Female

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Race: \_\_\_\_\_

7. Occupation: \_\_\_\_\_

8. Cause of Death: \_\_\_\_\_

9. Manner of Death: \_\_\_\_\_

10. Signature of Medical Examiner: \_\_\_\_\_

11. Date: \_\_\_\_\_

12. Place: \_\_\_\_\_

13. Signature of Coroner: \_\_\_\_\_

14. Date: \_\_\_\_\_

15. Place: \_\_\_\_\_

16. Signature of Registrar: \_\_\_\_\_

17. Date: \_\_\_\_\_

18. Place: \_\_\_\_\_

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5805

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>				c. LENGTH OF STAY IN 1b <b>25 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Allen</b> Last <b>Magaha</b>				4. DATE OF DEATH Month <b>5</b> Day <b>2</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/28/1890</b>	9. AGE (In years last birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR Months <b>69</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>railway trainman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S./</b>
13. FATHER'S NAME <b>Allen R. Magaha</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Flook</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-10-5930</b>		INFORMANT <b>Ellsworth Magaha, Middletown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Cardiovascular</b> (c) <b>Arterio-sclerosis &amp; Hypertensive disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Middletown</b>	(County) <b>Middletown</b>	(State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>Apr 1959</b> to <b>May 2 1960</b> , that I last saw the deceased alive on <b>May 1 1960</b> , and that death occurred at <b>3:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Middletown</b> DATE SIGNED <b>5-3-60</b>							
ACTUAL SIGNATURE <b>Elmer Harp</b>		M.D. <b>Middletown</b>					
PHYSICIAN'S NAME (Type) <b>Dr. J. Elmer Harp</b>		<b>Middletown, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5/4/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) <b>Middletown, Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				ADDRESS <b>Gladhill Company, Middletown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED  
FEB 10 1964  
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE  
BUREAU OF PUBLIC HEALTH

CERTIFICATE OF DEATH

2002

1. Name of deceased: [Illegible]

2. Sex: [Illegible]

3. Age: [Illegible]

4. Date of birth: [Illegible]

5. Place of birth: [Illegible]

6. Date of death: [Illegible]

7. Time of death: [Illegible]

8. Cause of death: [Illegible]

9. Place of death: [Illegible]

10. Signature of physician: [Illegible]

11. Signature of registrar: [Illegible]

12. Date of registration: [Illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

Item 20 Film 263 5-20-60 ams									
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5773 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 05755									
1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Airy R 7 A 3</u> <u>06X-2</u>			d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hosp.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Paul Maloney Jr</u>					4. DATE OF DEATH Month Day Year <u>May 5 1960</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 11, 1916</u>		9. AGE (In years, last birthday) <u>43</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truckster</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>William Paul Maloney</u>					14. MOTHER'S MAIDEN NAME <u>Emma Brown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW # 1</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>212-124522</u>		17. INFORMANT <u>Mrs Wm P. Maloney Jr Mt Airy R 53</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u> <u>822 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto crossed highway, struck stones &amp; overturned</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>11:30</u> <u>p.m.</u> <u>5/5</u> <u>1960</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 144</u>		20f. (City or town) (County) (State) <u>Ridgerville Frederick Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>B. O. Thomas, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/6/60</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>May 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>			22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clin L. Molsworth</u>					ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5774

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05756

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles U. Mehring</b>				4. DATE OF DEATH Month Day Year <b>May 7 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 24, 1898</b>	
9. AGE (In years last birthday) <b>61 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Truck Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Upton F. Mehning</b>				14. MOTHER'S MAIDEN NAME <b>Emma M. Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>218-32-4850</b>			
17. INFORMANT <b>Mrs. Charles U. Mehning, Keymar, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>5 yrs +</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 6, 1960</b> to <b>May 7, 1960</b> , that (I) (we) last saw the deceased alive on <b>May 7, 1960</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Henry V. Chase</b>				22b. DATE SIGNED <b>5/8/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>				22d. ADDRESS <b>4 E. Church St Frederick, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>May 10, 1960</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Haugh's Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Ladiesburg, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son,</b>				25a. REC'D BY REGISTRAR <b>Taneytown, Maryland</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>				DATE <b>MAY 10 '60</b>			

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STATE OF TEXAS

1977

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## CERTIFICATE OF DEATH

Reg. Dist. No.

5775

05757

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jack</b> Middle <b>Moffett</b> Last <b>Moffett</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25-1924</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. IF UNDER 1 YEAR Months <b>35</b> Days <b>14</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Research Chemist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lime Company</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis R. Moffett-Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Fox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>236-20-5393</b>	
17. INFORMANT <b>Mrs. Jack Moffett- Rt. 6- Frederick- Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, acute</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arterio-sclerosis coronary</b> DUE TO (c) <b>arteries</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>24 hours</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 9, 1960</b> to <b>May 14, 1960</b> that I last saw the deceased alive on <b>May 13, 1960</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bartholomew O. Thomas, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>228 N Market St. Frederick, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas, Jr.</b>		DATE SIGNED <b>5/14/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-17-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Milford Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>West Milford-West Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dailey's Funeral Home- Frederick- Maryland</b> <b>E. S. Whitmore</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 17 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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Page 4  
The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5776

05758

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>13 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>G.</b> Last <b>NAILLE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/8/1922</b>	
9. AGE (In years last birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>bird keeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>bird breeding</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Daniel A. Gaylor</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Knadler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>218-38-1972</b>		17. INFORMANT <b>Miss Ruth E. Naille, 469 W. Patrick St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>11 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (11) (this hospital) attended the deceased from <b>4/1/60</b> to <b>5/9/60</b> , that (11) (we) last saw the deceased alive on <b>5/9/60</b> and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard C. Reynolds,</b>				22b. DATE SIGNED <b>5/10/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Richard C. Reynolds</b>	
22d. ADDRESS <b>Frederick, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/12/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Locust Valley Cemetery, Frederick Co., Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>William S. House</b>	

00550

CERTIFICATE OF DEATH

00550

11



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5777

## CERTIFICATE OF DEATH

Reg. Dist. No. 05759

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 East Second Street</b>		d. STREET ADDRESS <b>11 East Second Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>JOHN</b> Last <b>NESTOR</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> , Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1999</b>
9. AGE (In years last birthday) <b>61</b>		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Credit Bureau</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manager</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John T. Nestor</b>		14. MOTHER'S MAIDEN NAME <b>Brigid Lynch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-05-4464</b>	
17. INFORMANT <b>Mrs. Cecelia M. Nestor— Same as Item #2</b>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>9/1</b> , 19 <b>59</b> , to <b>5/13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>5/13</b> , 19 <b>60</b> , and that death occurred at <b>6:00A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>5/16/1960</b>			
ACTUAL SIGNATURE <b>Richard C. Reynolds, M.D.</b>		ADDRESS (Street, city or town, state) <b>East Church Street</b>	
PHYSICIAN'S NAME (Type) <b>R. C. Reynolds, M.D.</b>		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 17, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	22d. LOCATION (City, town, or county) <b>Fort Myer</b> , (State) <b>Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS _____	
24a. REC'D BY REGISTRAR DATE <b>MAY 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Cecil S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No. 05760

5778

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Unknown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Ray</b> Last <b>Oates</b>				4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 18, 1895</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Winchester, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Robert Oates</b>				14. MOTHER'S MAIDEN NAME <b>Emma S. Nelson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mr. Roger U. Delauter (Nephew) Ijamsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> 182.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>12 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/24</b> , 19 <b>60</b> , to <b>5/3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>5/3</b> , 19 <b>60</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick, Maryland</b> DATE SIGNED <b>5-4-1960</b>							
ACTUAL SIGNATURE <b>Richard C. Reynolds</b>		M.D. <b>9 East Church Street Frederick, Md.</b>					
PHYSICIAN'S NAME (Type) <b>Dr. Richard C. Reynolds</b>		M.D. <b>9 East Church Street Frederick, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 5, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dailey</b>				ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 6 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

ACU M-1000

5772

CERTIFICATE OF DEATH

Frederick

John

Frederick

Frederick

Frederick

Frederick

Frederick

May 3, 1940

May

May

October 12, 1940

May

May

May

Frederick

Frederick

Frederick

John

John

John

John

John

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
executing certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5779 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05761

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Hrs.</b> <b>11</b> <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>121 Ice Street</b>	
3. NAME OF DECEASED (Type or print) <b>Lewis</b> First <b>Onley</b> Middle <b>Onley</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Ne gro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 30-1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles E. Onley</b>		14. MOTHER'S MAIDEN NAME <b>Martha Nichol</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Robert Onley</b> Address <b>6 Lincoln Apts. Fred. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Portal Cirrhosis of Liver; Severe electrolyte imbalance</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Portal Cirrhosis of Liver; Severe electrolyte imbalance</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, Sr., M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-21-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hope Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks</b>		24a. REC'D BY REGISTRAR <b>MAY 26 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5792

## CERTIFICATE OF DEATH

05762  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>				c. LENGTH OF STAY IN 1b <b>50 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>William</b> Last <b>Poole</b>				4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 1, 1875</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WMRR</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Poole</b>				14. MOTHER'S MAIDEN NAME <b>Mary C. Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-5870</b>		INFORMANT <b>Mrs. Wade Stull</b>		Address <b>Thurmont, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease Acute myocardial failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Heart disease, Chronic Atherosclerotic</b> DUE TO (c) <b>1 1/2 yrs</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recent Influenza moderately severe</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 10, 1960</b> to <b>May 13, 1960</b> that I last saw the deceased alive on <b>May 12, 1960</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont - Md.</b> DATE SIGNED <b>May 14-60</b>							
ACTUAL SIGNATURE <b>James T. Gray</b>		M.D. <b>James K. Gray</b>					
PHYSICIAN'S NAME (Type) <b>James K. Gray</b>		<b>Thurmont - Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-15-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lewistown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lewistown, Fred Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>				ADDRESS <b>Thurmont, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 16 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

BP

TEMPERATURE OF DEATH

1912

Marriage

Marriage

Marriage

Marriage

Marriage

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5793

## CERTIFICATE OF DEATH

Reg. Dist. No.

05763

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Utica Thurmont RD 1</b>		c. LENGTH OF STAY IN lb <b>80 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Ann</b> Last <b>Ramsburg</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21, 1877</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob H. Eichelberger</b>		14. MOTHER'S MAIDEN NAME <b>Emma Jane Freshour</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Harvey Ramsburg</b>		Address <b>Thurmont, Md. RD 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1940</b> to <b>May 12, 1960</b> , that I last saw the deceased alive on <b>May 12, 1960</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H.F. Kline</b>		DATE SIGNED <b>7-11-60</b>	
PHYSICIAN'S NAME (Type) <b>H.F. Kline</b>		ADDRESS (Street, city or town, State) <b>7 North Market St. Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-25-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Utica Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Utica Fred. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Frank</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72-hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1903

State of New York, County of New York, City of New York.

I, the undersigned, a duly qualified and licensed physician, do hereby certify that

Jan. 21, 1917

XX

Female

U.S.A. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5806

CERTIFICATE OF DEATH

05764

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Jefferson</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenmerrie Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Gertrude</b> Last <b>Riser</b>		4. DATE OF DEATH Month <b>5</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-1869</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>9</b> Hours <b>4</b> Min.	11. IF UNDER 24 HRS. Months <b>10</b> Days <b>9</b> Hours <b>4</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James West</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mr. R. R. Riser, Brunswick, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hem</b> <b>33 IX</b> DUE TO <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) <b>Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4/27/60</b> <b>10 9 4</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/29</b> , 19 <b>58</b> to <b>5/3</b> , 19 <b>60</b> that I last saw the deceased alive on <b>5/1</b> , 19 <b>60</b> , and that death occurred at <b>2:30</b> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. G. F. Smith</b> M.D.		ADDRESS (Street, city or town, state) <b>Brunswick, Maryland</b> DATE SIGNED <b>5-4-1960</b>	
PHYSICIAN'S NAME (Type) <b>J. G. F. Smith</b>		<b>Brunswick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-5-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Felt</b>		ADDRESS <b>Brunswick, Maryland</b>	
24a. REC'D BY REGISTRAR <b>MAY 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

CERTIFICATE OF DEATH

5886

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DECEASED

CAUSE OF DEATH

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5780

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05765

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 FREDERICK, MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MRS. MAY</u> <u>RORAPUGH</u>		4. DATE OF DEATH Month Day Year <u>MAY</u> <u>19</u> <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-80</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>MORRISON IL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>MR. ALFONSO GRAPER (D)</u>		14. MOTHER'S MAIDEN NAME <u>LIZZIE BRUMAGIN (D)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>197-03-6152 D.</u>	
17. INFORMANT <u>FREDERICK MEMORIAL HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.8</u> IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> 19 <u>60</u> to <u>5/18</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>5/18</u> 19 <u>60</u> , and that death occurred at <u>4:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard C. Reynolds</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard C. Reynolds, M.D.</u>		22d. ADDRESS <u>9, E. Church St. Frederick, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>May 21, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lewisberry Pennsylvania</u>	
24. FUNERAL DIRECTOR'S NAME <u>DALEY'S FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>FREDERICK, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>		25c. DATE <u>MAY 23 '60</u>	



1333

CERTIFICATE OF DEATH

05787

1914

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## CERTIFICATE OF DEATH

Reg. Dist. No.

5887

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#7</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Rocky Springs</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ABBIE</b> Middle <b>MARIE</b> Last <b>SHAFFER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 April 1890</b>	9. AGE (In years last birthday) <b>70</b> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Forney</b>				14. MOTHER'S MAIDEN NAME <b>Ada Rhoades</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James E. Shafer (Same as item #1)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolization</b> DUE TO <b>Auricular Fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-Sclerotic heart dis.</b> (c) <b>3 wks.</b> <b>4 yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b> <b>4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>56</b> to <b>1 May</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1 May</b> , 19 <b>60</b> , and that death occurred at <b>2:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>228 N. Market St.</b> DATE SIGNED <b>4 May 1960</b>							
ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b> M.D.				Frederick, Maryland			
PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr., M.D.</b>				Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-4-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5781

05767

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN lb <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Horace</b> Middle <b>Gregory</b> Last <b>Sigafoose</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-12-1889</b>	
9. AGE (In years lost birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.		IF UNDER 24 HRS. Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Yard Master B.&amp;O.R.R.Co</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John S. Sigafoose</b>				14. MOTHER'S MAIDEN NAME <b>Annie Staub</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NO</b>			
17. INFORMANT <b>Mrs. Maude Welty, Martinsburg, W. Va.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, extensive</b> DUE TO (b) <b>Chronic Bronchitis</b> DUE TO (c) <b>Coronary of the stomach</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>20 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary of the stomach</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 16</b> , 19 <b>60</b> , to <b>May 30</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>May 29</b> , 19 <b>60</b> , and that death occurred at <b>8:40</b> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <b>Henry V. Chase</b>				22b. DATE SIGNED <b>5/30/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>				22d. ADDRESS <b>4 E. Church St Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-3-1960</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Reformed</b>				23d. LOCATION (City, town, or county) (State) <b>Knoxville, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. W. Tute</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 1 '60</b>			
ADDRESS <b>Brunswick, Maryland</b>				25b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>			

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5782

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film G264 6-6-60 et

05768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodsboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Alvey</b> Middle <b>Newton</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>5</b> Day <b>31</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 21, 1918</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fred. Iron &amp; Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick County, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>George O. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Lucy C. Orndorff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-18-1095</b>	
17. INFORMANT <b>Mrs Louise J. Smith, Woodsboro, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Arterial Coronary Thrombosis</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Heart Disease</b> DUE TO (c) <b>Old Posterior Coronary -healed</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/3/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rocky Hill</b>	22d. LOCATION (City, town, or county) (State) <b>W. Woodsboro Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. E. Barton, Walkersville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 3 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT



STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
Baltimore, Md.

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH, AND IS TO BE RETURNED TO THE DIVISION OF PUBLIC HEALTH, BALTIMORE, MARYLAND, WITH THE BODY.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PROVIDENCE

1-1-1918

Foot date

MASSACHUSETTS

PROVIDENCE

Body in

Ally

Child

County of PROVIDENCE, State of MASSACHUSETTS

Deceased, in County, M. D.

Jan 1, 1918

1-1-1918

Adults Hospital Providence

Providence Hospital

Old Providence Hospital - aged

THE DECEASED WAS FOUND BY THE PHYSICIAN

2. I certify that the deceased was found by the physician, and that the cause of death was as stated above.

PROVIDENCE

PROVIDENCE

PROVIDENCE

PROVIDENCE

PROVIDENCE

PROVIDENCE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5808

CERTIFICATE OF DEATH

Reg. Dist. No.

05769

1. PLACE OF DEATH a. COUNTY <u>FREDERICK COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>BAKER</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 20, 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ISAAC BAKER</u>		14. MOTHER'S MAIDEN NAME <u>TENNIE Moulton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
INFORMANT <u>CHARLES H. SMITH</u>		Address <u>RURAL UNION BRIDGE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Acute dilatation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 6, 1960</u> , to <u>May 18, 1960</u> , that I last saw the deceased alive on <u>5-20</u> , 19 <u>60</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Legg</u> M.D.		ADDRESS (Street, city or town state) <u>Union Bridge 5-21-60</u>	
PHYSICIAN'S NAME (Type) <u>T. H. LEGG MD</u>		<u>UNION BRIDGE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 23, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRMOUNT CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>LIBERTY TOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. W. 3 Carter + Sons</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAY 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

5802

CERTIFICATE OF DEATH

1930

(M)

(1)

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5783

Reg. Dist. No. 05770

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Frederick</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>			d. STREET ADDRESS <b>205 Grove Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Gorden</b> Middle <b>Wilber</b> Last <b>Spurrier</b>			4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 4, 1909</b> 51 yrs.		9. AGE (In years last birthday) <b>51</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real estate broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>20 years</b>	11. BIRTHPLACE (State or foreign country) <b>Frederick</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Dorsey W. Spurrier</b>			14. MOTHER'S MAIDEN NAME <b>Dora Ball</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>2 World Wsr</b>	17. INFORMANT Address <b>Frederick, Md.</b> <b>Mrs Grace Spurrier 205 Grove Blvd.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 8, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 11, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dillig</b>		ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 12 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>



5809

## CERTIFICATE OF DEATH

Reg. Dist. No.

05771

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.D.#6</b>				c. LENGTH OF STAY IN 1b <b>30 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Jug Bridge</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GLENNA</b> Middle <b>MAY</b> Last <b>STALEY</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> , Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 14, 1887</b>	
9. AGE (In years last birthday) yrs. <b>72</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles E. Routzhan</b>				14. MOTHER'S MAIDEN NAME <b>Ida May Long</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. John H. Staley, Sr.</b> Address <b>—Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>153.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>13 mos</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>59</b> , to <b>May</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>13 May</b> , 19 <b>60</b> , and that death occurred at <b>6:12 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Building</b> DATE SIGNED <b>5/16/1960</b> ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr., M. D.</b> <b>Frederick, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 18, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAY 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1952-53 2000-01

Q. Now, you're going to tell me that the defendant was not in the car at the time of the shooting, is that correct?

2.



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5784  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND  
CERTIFICATE OF DEATH

05772

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - R.F.D. #1 Mt. Airy</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>1 Near New Market</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CARL</b> Middle <b>MERCER</b> Last <b>STEVENS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1960</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/3/00</b>		9. AGE (In years last birthday) <b>59 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painter</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles I. Stevens</b>				14. MOTHER'S MAIDEN NAME <b>Mary J. Crum</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-05-6804A</b>		17. INFORMANT <b>Mrs. Nellie Roderick; R.F.D. #1 Mt. Airy, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>491X</b> IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Amputation both legs because of A.S. gangrene both feet</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/22</b> <b>1960</b> to <b>5/11</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>5/10</b> <b>1960</b> , and that death occurred at <b>9:25</b> <b>AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert H. Pilgram M.D.</b>				22b. DATE SIGNED <b>5/11/60</b>		22c. ADDRESS <b>Frederick, Md.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert H. Pilgram</b>							
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Co. Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son; Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05773

Reg. Dist. No.

5785

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Frederick Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Franklin</u> Last <u>Stone, Jr.</u>				4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>30 May 60</u>	
9. AGE (In years lost birthday) yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Franklin Stone, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Virginia Moser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mother</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atelectasis</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>At birth</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>31 May 1960</u> , to <u>31 May 1960</u> , that I last saw the deceased alive on <u>31 May 1960</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.M. Powell, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>1 June 60</u>			
PHYSICIAN'S NAME (Type) <u>A. M. Powell, Jr.</u>				Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 2 - 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>		22d. LOCATION (City, town, or county) (State) <u>WOODSBORO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cramer Powell Woodboro Md</u> <u>Byron Hartzler New Windsor Md</u>				24a. REC'D BY REGISTRAR <u>JUN 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	

2069213XV4

CERTIFICATE OF DEATH

1. PLACE OF DEATH City or Town		2. COUNTY	
3. DATE OF DEATH		4. TIME OF DEATH	
5. NAME OF DECEASED		6. SEX	
7. AGE		8. OCCUPATION	
9. MARITAL STATUS		10. COLOR	
11. PLACE OF BIRTH		12. DATE OF BIRTH	
13. NAME OF FATHER		14. NAME OF MOTHER	
15. NAME OF SPOUSE		16. NAME OF CHILDREN	
17. NAME OF NEXT OF KIN		18. NAME OF PHYSICIAN	
19. NAME OF FUNERAL HOME		20. NAME OF BURIAL PLACE	
21. NAME OF MINISTER		22. NAME OF CHURCH	
23. NAME OF CEMETERY		24. NAME OF INTERMENT	
25. NAME OF CARRIER		26. NAME OF DRIVER	
27. NAME OF ASSISTANT		28. NAME OF ATTENDANT	
29. NAME OF Usher		30. NAME OF Organist	
31. NAME of other persons present		32. NAME of other persons present	
33. NAME of other persons present		34. NAME of other persons present	
35. NAME of other persons present		36. NAME of other persons present	
37. NAME of other persons present		38. NAME of other persons present	
39. NAME of other persons present		40. NAME of other persons present	
41. NAME of other persons present		42. NAME of other persons present	
43. NAME of other persons present		44. NAME of other persons present	
45. NAME of other persons present		46. NAME of other persons present	
47. NAME of other persons present		48. NAME of other persons present	
49. NAME of other persons present		50. NAME of other persons present	
51. NAME of other persons present		52. NAME of other persons present	
53. NAME of other persons present		54. NAME of other persons present	
55. NAME of other persons present		56. NAME of other persons present	
57. NAME of other persons present		58. NAME of other persons present	
59. NAME of other persons present		60. NAME of other persons present	
61. NAME of other persons present		62. NAME of other persons present	
63. NAME of other persons present		64. NAME of other persons present	
65. NAME of other persons present		66. NAME of other persons present	
67. NAME of other persons present		68. NAME of other persons present	
69. NAME of other persons present		70. NAME of other persons present	
71. NAME of other persons present		72. NAME of other persons present	
73. NAME of other persons present		74. NAME of other persons present	
75. NAME of other persons present		76. NAME of other persons present	
77. NAME of other persons present		78. NAME of other persons present	
79. NAME of other persons present		80. NAME of other persons present	
81. NAME of other persons present		82. NAME of other persons present	
83. NAME of other persons present		84. NAME of other persons present	
85. NAME of other persons present		86. NAME of other persons present	
87. NAME of other persons present		88. NAME of other persons present	
89. NAME of other persons present		90. NAME of other persons present	
91. NAME of other persons present		92. NAME of other persons present	
93. NAME of other persons present		94. NAME of other persons present	
95. NAME of other persons present		96. NAME of other persons present	
97. NAME of other persons present		98. NAME of other persons present	
99. NAME of other persons present		100. NAME of other persons present	

5786

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Miss Ruth</b> First Middle Last <b>REBECCA TROUT</b>		4. DATE OF DEATH <b>May 2 1960</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 5, 1901</b>
9. AGE (In years, last birthday yrs.) <b>58</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. in Charge</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accounting</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>	
13. FATHER'S NAME <b>Samuel C. Trout</b>		14. MOTHER'S MAIDEN NAME <b>Laura R. Biehl</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-36-3099</b>	
17. INFORMANT <b>Mr. J. David Trout</b>		738 North Market Street, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of the Lung &amp; Bones</b> DUE TO (b) <b>Carcinoma of the Breast</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 1, 1959</b> to <b>May 2, 1960</b> that I last saw the deceased alive on <b>May 2, 1960</b> and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. A. Pearre</b>		DATE SIGNED <b>5/3/60</b>	
PHYSICIAN'S NAME (Type) <b>A. A. Pearre, M. D.</b>		<b>Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 6, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 9 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5790

## CERTIFICATE OF DEATH

05775  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN 1b <b>35 Brunswick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>17 North MD. Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Michael</b> Last <b>Troxell</b>		4. DATE OF DEATH Month <b>5</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R. R. Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred Troxell</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Krause</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Lena Troxell, Brunswick, Maryland</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>434.1</b> IMMEDIATE CAUSE (a) <b>Decompensated Congestive Heart Failure</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 17</b> , 19 <b>58</b> , to <b>May 14</b> , 19 <b>60</b> that I last saw the deceased alive on <b>May 14</b> , 19 <b>60</b> , and that death occurred at <b>6:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>15 So. Maryland Ave.</b> DATE SIGNED ACTUAL SIGNATURE <b>C. T. Byron Kao, M.D.</b> PHYSICIAN'S NAME (Type) <b>Brunswick, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-17-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Felt</b> <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 20 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>			



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05776

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa</b> b. COUNTY <b>Huntingdon</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.D.#5</b>		c. LENGTH OF STAY IN 1b <b>Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Shade Gap</b>		75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Junction of U.S. 40 &amp; 40 A</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>Dale</b> Last <b>Watters</b>				4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 60</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 18 1919</b>	9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Huntingdon Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Porter J. Watters</b>				14. MOTHER'S MAIDEN NAME <b>Alice Armintha</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W 1111</b>		17. INFORMANT <b>John F. Kelso, McConnellsburg Pa</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DECAPITATED HEAD</b> <b>816X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CRUSHED CHEST</b> DUE TO (c) <b>Multiple Fractures</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between ONSET AND DEATH Instant</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Injured in front of trailer tractor</b>					
20c. TIME OF INJURY Month, Day, Year <b>5/20 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40</b>		20f. (City or town) (County) (State) <b>Frederick Frederick Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 23, 60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Huntingdon Co. Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; SON, Frederick, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



WATLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
FACIAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: \_\_\_\_\_  
 SEX: \_\_\_\_\_ AGE: \_\_\_\_\_  
 OCCUPATION: \_\_\_\_\_  
 PLACE OF BIRTH: \_\_\_\_\_  
 DATE OF DEATH: \_\_\_\_\_  
 TIME OF DEATH: \_\_\_\_\_  
 CAUSE OF DEATH: \_\_\_\_\_  
 MANNER OF DEATH: \_\_\_\_\_  
 SIGNATURE OF EXAMINER: \_\_\_\_\_  
 TITLE OF EXAMINER: \_\_\_\_\_

DATE	TIME	PLACE	CAUSE	MANNER
11				
11				

REMARKS: \_\_\_\_\_  
 SIGNATURE OF PHYSICIAN: \_\_\_\_\_  
 TITLE OF PHYSICIAN: \_\_\_\_\_  
 SIGNATURE OF EXAMINER: \_\_\_\_\_  
 TITLE OF EXAMINER: \_\_\_\_\_

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5787

## CERTIFICATE OF DEATH

Reg. Dist. No.

05777

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. STREET ADDRESS <b>300 West Fifth Street</b>			
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>HENDRICKS</b> Last <b>WEHLER</b>				4. DATE OF DEATH Month <b>May 20,</b> Day <b>19,</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1864</b>	9. AGE (In years last birthday) <b>95</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph H. Hendricks</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Hunsicker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Miss Katherine Wehler—Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of ascending colon</b> DUE TO (b) <b>c closed loop obstruction of cecum</b> DUE TO (c) <b>unk.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>16 May, 1960</b> , to <b>19 May, 1960</b> , that I last saw the deceased alive on <b>19 May, 1960</b> , and that death occurred at <b>12:15 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Melvin E. Lea</b>			ADDRESS (Street, city or town, state) <b>Medical Arts Center</b>			DATE SIGNED <b>5/21/60</b>	
PHYSICIAN'S NAME (Type) <b>Melvin E. Lea, M. D.</b>			Frederick, Maryland				
22a. BURIAL, CREMATION, REMQVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 23, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick,</b>	(State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 24 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hens</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		TIME OF BIRTH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	



This certificate is to be filled out by the physician or other person who has attended the deceased, and is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be filled out in duplicate, one copy to be retained in the office of the Registrar, and the other copy to be retained in the office of the physician or other person who has attended the deceased.



## CERTIFICATE OF DEATH

Reg. Dist. No. 05778

5811

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural- R.F.D.#4</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural- R.F.D.#4</b>				d. STREET ADDRESS <b>Feagaville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Feagaville</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>EMORY</b> Middle <b>SAMUEL</b> Last <b>WHIPP</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 28, 1880</b>		9. AGE (In years last birthday) yrs. <b>79</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel M. Whipp</b>				14. MOTHER'S MAIDEN NAME <b>Mary J. R. Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Mary V. Goodsell-Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - Cystitis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Generalized arteriosclerosis</b> DUE TO (c) <b>Malnutrition</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 yrs</b> <b>3 mo</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Deep Throat Infection</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 3, 1960</b> to <b>May 5, 1960</b> , that I last saw the deceased alive on <b>May 5, 1960</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Jefferson, Maryland</b> DATE SIGNED <b>5/9/60</b>							
ACTUAL SIGNATURE <b>A. T. Brice</b>		M.D. <b>Jefferson, Maryland</b>		DATE SIGNED <b>5/9/60</b>			
PHYSICIAN'S NAME (Type) <b>A. T. Brice, M.D.</b>		Same					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 9, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Feagaville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 10 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kins</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5788

05779  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>200 East Church Street</b>				d. STREET ADDRESS <b>200 East Church Street</b>			
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>RHODES</b> Last <b>WHIPP</b>				4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1916</b>		9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nat. Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David C. Whipp</b>				14. MOTHER'S MAIDEN NAME <b>Maude <del>Scupper</del> Kreps</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW2 214-16-1650</b>		17. INFORMANT <b>Personal Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>973.3</b> IMMEDIATE CAUSE (a) <b>CARBON MONOXIDE POISONING</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-27-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Fort Myer, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H...</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH OFF.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7227

NAME - LAST  
FIRST

Frederick

Residence

1001

Age and Sex

1001 and 1002

1. Date of Birth  
2. Sex

Male

White

Married

1001

1. Cause of Death

1001-1002

1001-1002

1. Date of Death  
2. Time of Death  
3. Place of Death

1. Date of Death  
2. Time of Death  
3. Place of Death

1. Date of Death  
2. Time of Death  
3. Place of Death

1. Date of Death  
2. Time of Death  
3. Place of Death

1. Date of Death  
2. Time of Death  
3. Place of Death

3/10/1900

1. Date of Death  
2. Time of Death  
3. Place of Death

## CERTIFICATE OF DEATH

05780  
Reg. Dist. No.

5794

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>				c. LENGTH OF STAY IN 1b <b>50 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Florence</b> Last <b>Wills</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1875</b>	9. AGE (In years last birthday) yrs. <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hiram Zimmerman</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Seacrist</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-7306</b>		INFORMANT Address <b>Mrs. Edith Kelly Thurmont, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA-</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Rehydration</b> DUE TO (c) <b>Chronic NSCD</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>3 weeks</b> <b>20 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture Ribs</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-58</b> , 19 <b>58</b> , to <b>5-30-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>5-30-60</b> , 19 <b>60</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Thos A. Love</b> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Thomas A. Love</b>				<b>Thurmont, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-2-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Md. Fred Co.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>				ADDRESS <b>Thurmont, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 3 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

03780

CERTIFICATE OF DEATH

1938



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